CYSTIC TUMORS OF THE VAGINAL VAULT,

WITH REPORTS OF TWO CASES.

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REPRINTED FROM THE

New York Medical Journal

for July 13, 1895.

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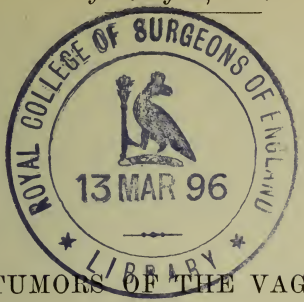

CYSTIC TUMORS OF THE VAGINAL VAULT,

*WITH REPORTS OF TWO CASES.**

By FREDERICK HOLME WIGGIN, M. D.,
VISITING SURGEON TO THE NEW YORK CITY HOSPITAL (B. I.), GYNÆCOLOGICAL DIVISION, ETC.

Cystic tumors of the anterior vaginal wall which occupy the space between this wall and the inferior wall of the bladder are of interest on account of their rarity. The first case which I shall report this evening is especially so as it is of that variety which does not communicate with the urethra. Dr. Cullen, of the Johns Hopkins Hospital, found records of only two such cases to April, 1894; while, of the cystic tumors of this region which did communicate with or form a part of the urethra, he found records of thirty-two cases. To this variety my second case belongs:

Case I.—The patient, a prostitute, twenty-six years of age, was admitted to the Penitentiary Hospital, Blackwell's Island, during April, 1894. She stated that just after a miscarriage she first noticed a swelling on the anterior vaginal wall, slightly posterior to the labia minora. Up to that time she had had no pain during micturition or coitus. She stated that she had not to her knowledge received any injury to this part. At the time

* Read before the Society of Alumni of Bellevue Hospital, June 5, 1895.

of admission to the hospital the patient complained of a constant dragging pain and of a profuse leucorrhœa. A vaginal examination revealed a protrusion or prolapse of the anterior vaginal wall, external to the labia. At first it was supposed that the patient was suffering from a cystocele, but her age and previous history led to a closer examination, and a catheter was passed into the bladder. It was found that the tumor, which was about three by two inches, was not connected with that viscus. It was somewhat movable and sessile. Under ether anæsthesia an incision was made along the anterior vaginal wall, starting from a point about an inch below the meatus and extending to the junction of the anterior vaginal wall with the cervix. These flaps were dissected from the tumor. A sound was at this time introduced into the bladder and the thickness of the vesical wall was measured. The separation of the tumor from this wall was not attended with difficulty, although in the course of the dissection the wall of the cyst was ruptured at one point and its contents escaped. It contained about four ounces of a glairy, semitransparent fluid. There was no appearance of pus or blood. The wound was irrigated with a 1-to-4,000 solution of bichloride of mercury, and then with a solution of hydrogen dioxide. The wound was closed with two layers of catgut sutures, deep and superficial, and the wound painted over with a ten per-cent. solution of iodoform in ether. Union occurred primarily. The specimen was referred to Dr. Edward K. Dunham, of the Carnegie Laboratory, for a histological examination. He reported that the cyst had fibrous walls, and that it was lined with epithelial cells. He writes: "I can not state whether the cyst is congenital or not."

Case II.—This patient was seen by the courtesy of Dr. Charles Phelps, a member of this society, in consultation.

M. W., twenty-three of age, a married woman, gave a good family history. Her health had always been satisfactory. Her first menstruation occurred during her thirteenth year, and it has been painless, regular, and of the monthly type. She was married in November, 1894, and her last menstrual period began on December 5, 1894. Up to March, 1895, nothing unusual was noticed by her about her vagina. Coition and mictu-

rition were unattended with pain. She first became aware about this time of a brownish discharge from her vagina, or rather her urethra, and soon after this she noticed a swelling which did not, according to her story, increase in size from the time of its discovery in March till the day of operation, May 14, 1895. When a vaginal examination was made, a tumor on the anterior vaginal wall was found, beginning at the lower margin of the meatus urinarius and extending about an inch and a half along this wall. The tumor was about an inch in breadth. An opening into the urethra was discovered, and the tumor could be partially emptied through this opening. Under ether anæsthesia the sac was excised. Much difficulty was experienced in making this dissection on account of the intimate connection between the walls of the cyst and that of the urethra. After irrigation the wound was closed with catgut sutures, and the patient's urine was drawn by a catheter for several days. Her recovery was uneventful. Unfortunately, in the confusion which followed the operation (it having taken place in a private house), the specimen was lost.

Huguier, Virchow, Guérin, Preuschen, Poupinel, and others believe that these cysts generally derive their origin from glands, and are therefore retention cysts. Eustache, Tillaux, and Thallinger believe that they are hygromata; Viet, that they derive their origin from the terminal extremity of the Wolffian canal, or Gartner's duct. "I believe," says Professor Pozzi, "that all vaginal cysts larger than a walnut are of embryonic origin." Courty thinks excessive coitus is the most frequent cause. Cullen, in his article in the *Johns Hopkins Hospital Bulletin* for April, 1894, thinks that, in addition to the causes already alluded to (embryonic, traumatic, or glandular), we may have a true urethral diverticulum in which all the urethral coats take part; that they may be caused by the dilatation and possibly occlusion of Skene's tubules; that they may be due to the arrest of calculi in the urethra, a diverticulum forming to accommo-

date the same, or that a suppurating cyst situated in the urethro-vaginal junction may have burst into the ure hra.

The cases herewith reported give no history of traumatism, and it seems more probable that they were both cysts of Gartner's duct, and therefore congenital, than that they were glandular in origin, or retention cysts. The fact that the tumors were in both cases first noticed soon after the beginning of pregnancy supports Professor Pozzi's theory that their ætiology may depend on pregnancy, or, in other words, the active increase of the nutrition of the whole generative tract which takes place under such a condition may at times extend to the remains of the duct of Gartner, and the cyst result.

The symptoms which are usually manifest in this condition are painful micturition, and, after the tumor has reached certain proportions, profuse leucorrhœa and pro lapse of the anterior vaginal wall, accompanied by a con stant dragging pain. The treatment of these neoplasms should generally be their total extirpation. In the second case the severance of the tumor from its urethral attachments would have been facilitated if after the primary incision the sac had been punctured and evacuated and it had been filled with a solution of plaster of Paris or liquid paraffin, as suggested by Pozzi. After the removal of the tumor the wound should be irrigated with a bichloride solution. Hydrogen dioxide should then be applied to control the oozing. Two rows of sutures, preferably of silkworm gut, should be employed to close the wound, which should then be painted over with a ten-per-cent. solution of iodoform in ether. This must be renewed from time to time.

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Dermoid Cyst of the Right Superciliary Region.—Dr. Wiggin exhibited a specimen of this kind. The patient, J. K, an adult man, had been admitted to the Penitentiary Hospital, Blackwell's Island, early in June, 1894. He had had a tumor situated over his right eyebrow; fluctuating, movable, not adherent to the skin, and about an inch in diameter. The patient had stated that he had noticed that the tumor had varied in size from time to time. On June 11th, under ether anæsthesia, an incision an inch and a half long had been made, parallel with the eyebrow, and the tumor had been removed. The enucleation of the sac had been somewhat difficult, owing to the fact that it had been adherent to the periosteum. After its removal a shallow depression of the same diameter as the tumor had been noticed in the bone. The wound had been closed without irrigation, using silk sutures. It had then been dusted over with acetanilide and a gauze dressing applied. On opening the cyst it had been found to contain hair, white flakes, which had felt greasy, and oil. On June 13th the dressing and sutures had been removed, and a collodion-and acetanilide dressing applied. On June 23d the dressing had been again removed and union found to have occurred primarily, the cicatrix being barely visible.

DISCUSSION.

Dr. W. Evelyn Porter said that he had had a case in which there had been five separate cysts between the bladder and the vaginal wall. The appearance had been very much like that of a large cystocele, but on making a careful examination under ether anæsthesia it had been evident that there was a very considerable space between the urethra and the vaginal wall. Upon making a small incision through the vaginal surface, considerable yellowish, semi-transparent fluid had escaped. He had been unable to find any communication with the urethra. The large external cyst had been of about the size of the one just reported. In the course of the dissection he had found a small opening extending up farther into another much smaller cyst. Beyond this had been three smaller cysts communicating

with one another in the same manner. He had dissected them out without attempting to slit up the wall of the cysts. The raw edges had then been approximated, and the wound had healed primarily. The absence of any history of inflammatory trouble in this region had led him to believe that there was no such communication with the urethra. The patient was a married woman who had had children.

Dr. WIGGIN said that ordinarily these cysts were of about the size of a pea. Probably the case just reported by Dr. Porter was also one of that kind.

Dr. J. B. GIBBS said that cystic tumors of the labia nearly always appeared in married women or in prostitutes, and were slow in growth; they contained blood, clear fluid, or pus, and were lined with mucous membrane or the ordinary lining membrane of an abscess. From these facts he was inclined to think that they were for the most part the result of infection. The treatment was, of course, the same as for abscesses in other regions—incision or excision.

Dr. WIGGIN said that the remarks of the last speaker did not apply to his case, because tumors had not been in the labia, but between the anterior vaginal vault and the bladder.

Dr. CHANDLER remarked that in August, 1879, he had seen Dr. Pierson, of Orange, employ the method of dissecting out sinuses entire, and closing the wound by suture, and had supposed it to be original with him.

Dr. GIBBS said that the method dated back to the time when antiseptic surgery in New York had become very generally accepted—say 1881. The method often succeeded, but there was no way of being sure of getting a perfect result, and after all it only saved the patient some time.

Dr. GOULEY said that the origin of a cyst lined with epithelium must be either glandular, as in a retention cyst, or congenital. If the cyst described by Dr. Wiggin had been lined with endothelium it would be clearly one from a lymphatic space or vessel. He thought that the majority of the cysts in this region were due to the occlusion of the mouths of the glands. He recalled a case in which he had found a tumor at

the ostium vaginæ. It had been about an inch and a quarter in diameter, situated in the region of the vulvo-vaginal gland, and had probably been the result of closure of the duct of that gland. He had removed this cyst, as he had felt that this was the only method of securing a permanent cure. The wound had healed kindly.